Connecticut Department of Social Services
Medical Assistance Program
Provider Bulletin

PB 2006-65 **August 2006**

TO: **Freestanding Mental Health Clinics**

SUBJECT: **Connecticut Behavioral Health Partnership Procedures for Authorization and Registration of Home Based Services**

This bulletin is being sent to advise providers about the procedures for authorization and registration of home based services under the Connecticut Behavioral Health Partnership (CTBHP). Home based services are only available for clients under the age of twenty-one (21).

Registration
Effective for dates of service on or after September 1, 2006, DCF contracted providers of Family Support Team (FST) services must register those services with the CTBHP. Providers may register a client for FST services for a period of up to six months. This registration can be done via the CTBHP web registration process. Beginning August 1, 2006, providers may pre-register their currently active FST clients and obtain coverage for the six-month period beginning September 1, 2006. For clients entering FST treatment on or after September 1st, the web registration must be done within 30 days of the initiation of services. Successful registration will result in an authorization number and the issuance of an authorization letter with authorized units and dates. Detailed instructions about access to and use of the web-enabled registration system will be forthcoming from CTBHP. Providers will also receive information regarding alternative methods to register clients. Providers who have questions about the process should contact the Provider Relations staff at the CTBHP ASO by calling 1-877-552-8247.

When submitting claims for dates of service on or after September 1, 2006, the authorization number must be appropriately entered on the claim form.

Prior Authorization
Effective for dates of services on or after September 1, 2006 the following home based services will require prior authorization from the CTBHP: Multi-systemic Therapy (MST), Multi-dimensional Family Therapy (MDFT), Functional Family Therapy (FFT), Intensive In-home Child and Adolescent Psychotherapy Services (IICAPS) and any non-manualized, non-intensive home based therapy. Authorization must be obtained prior to the initiation of services for all clients entering these treatments on or after September 1, 2006. For clients currently in care on September 1st, providers will be able to send a faxed form to CTBHP at 1-866-584-4194 notifying CTBHP of the treatment. Providers will receive an authorization letter and an authorization number once this form is processed by CTBHP. In the event that CTBHP needs more clinical information about a case, CTBHP will contact the provider to complete the authorization process. A copy of the home based services notification form is attached to this bulletin. Successful authorization will result in an authorization number and the issuance of an authorization letter with authorized units and dates.

Intensive home based services including FST, MST, MDFT, FFT and IICAPS are billed using codes H2019 (Therapeutic behavioral services, per 15 minutes) and T1017 (Targeted case management, each 15 minutes). Providers of IICAPS services should use the modifier HK with each code.

Non-intensive home based services are billed using code H2019. Reimbursement for H2019 is limited to licensed or license-eligible behavioral health clinicians. Providers of non-intensive home based services are not eligible for reimbursement for code T1017.

When submitting claims for dates of service on or after September 1, 2006, the authorization number must be appropriately entered on the claim form.

This bulletin and other program information can be found at **www.ctmedicalprogram.com**.
Questions regarding this bulletin may be directed to the EDS Provider Assistance Center - Monday through Friday from 8:30 a.m. to 5:00 p.m. at:

In-state toll free ..... **800-842-8440** or
Out-of-state or in the
local New Britain, CT area **860-832-9259**

EDS
PO Box 2991
Hartford, CT 06104

REQUEST FOR CONTINUED CARE AUTHORIZATION FOR MEMBERS WHO BEGAN RECEIVING HOME BASED SERVICES PRIOR TO SEPTEMBER 1ST, 2006

PLEASE COMPLETE AND FAX TO: 1-(866)-584-4194

Name of clinician who filled out this form:_____

Degree and Credentials_____ Title:_____

Contact number: _____ Ext: _____

Facility: _____ Telephone Number: _____

Member Name:	
DOB:	SSN:
Medicaid/Consumer ID#:	
Actual date of Admission:	Level of Care: *(i.e. IICAPS, MST, FFT,MFT etc.)*

DSM IV DIAGNOSIS CODE:

AXIS I _____ **AXIS II** _____ **AXIS III** _____ **AXIS IV** _____ **AXIS V** _____

CLINICAL REVIEW: ***Please complete the following based on member's current clinical status:***	
Mood Disturbance	☐ NONE ☐ MILD ☐ MODERATE ☐ Severe ☐ N/A
Psychosis/Hallucinations/Delusions	☐ NONE ☐ MILD ☐ MODERATE ☐ Severe ☐ N/A
Thinking, Cognition, Memory, Concentration problems	☐ NONE ☐ MILD ☐ MODERATE ☐ Severe ☐ N/A
Impulsive, reckless, aggressive behavior.	☐ NONE ☐ MILD ☐ MODERATE ☐ Severe ☐ N/A
Job, school performance problems.	☐ NONE ☐ MILD ☐ MODERATE ☐ Severe ☐ N/A
Social Functioning, relationships, marital, family problems	☐ NONE ☐ MILD ☐ MODERATE ☐ Severe ☐ N/A
Weight Loss associated with an eating disorder	☐ NONE ☐ MILD ☐ MODERATE ☐ Severe ☐ N/A
ADL's	☐ NONE ☐ MILD ☐ MODERATE ☐ Severe ☐ N/A
Legal	☐ NONE ☐ MILD ☐ MODERATE ☐ Severe ☐ N/A
Substance Abuse/Dependence	☐ NONE ☐ MILD ☐ MODERATE ☐ Severe ☐ N/A

None = No evidence of impairment; **Mild** = Occasional impairment or difficulties, but no interference with normal daily activities; **Moderate** = Currently experiencing difficulties, frequent disruption in daily activities, requires periodic or continuous assistance with some tasks; **Severe** = Currently experiencing severe symptoms, potential risk for harm to self/others, severe distress and/r disruption in daily activities; **N/A**= Impairment was not assessed – Please note use of NA may result in additional questions to ascertain this information.

Are there barriers to discharge which are resulting in the need for continued care?	☐ YES ☐ NO
If so, please describe:_____	

Please note: Providers must call 1-877-552-8247 (1-877-55 CTBHP) <u>on the day of discharge or by SEPTEMBER 21st</u> (whichever occurs first) in order to receive authorization for reimbursement of services.